

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07433

DR/ VAN ORMER

7460 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 61 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FANNY Middle Y Last AMICK		4. DATE OF DEATH Month JULY Day 20 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 16
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WILLIAM MORELAND		14. MOTHER'S MAIDEN NAME MARTHA MATTHEWS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL AVENUE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with it. 332x DUE TO hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO Hypertensive Vascular Disease (c) 260x Diabetes mellitus 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18 mo. 58 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 May , 19 58 , to 20 July , 19 58 , that I last saw the deceased alive on 20 July , 19 58 , and that death occurred at 11:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer		ADDRESS (Street, city or town, state) 122 S. Cento St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. W. VAN ORMER		DATE SIGNED 22 July 58	
22a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL		22b. DATE THEREOF 7/23/58	
22c. NAME OF CEMETERY OR CREMATORY GINEVAN CEM.		22d. LOCATION (City, town, or county) (State) RURAL PAWPAW, W. VA	
23. FUNERAL DIRECTOR'S SIGNATURE Parker F. Horne @ Edgemoor		ADDRESS Buckley Springs W. Va.	
24a. REC'D BY REGISTRAR JUL 28 '58		24b. REGISTRAR'S SIGNATURE West	

DEATH CERTIFICATE OF DEATH

NAME

LAST NAME

FIRST NAME

DATE OF BIRTH

SEX

PLACE OF BIRTH

DATE OF DEATH

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

DECLARATION OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.
7461 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital			d. STREET ADDRESS 902 LaFayette Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Myrtle L Middle Bearinger Last			4. DATE OF DEATH Month July Day 29 Year 1958		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1891		9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	11. BIRTHPLACE (State or foreign country) Gaithersburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Durbin			14. MOTHER'S MAIDEN NAME Mary J. Norris		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Leoda M. Bearinger 902 LaFayette Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 30 Min;
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 29, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-I-58	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli James F. Scarpelli		24a. REC'D BY REGISTRAR JUL 31 '58		24b. REGISTRAR'S SIGNATURE Alfred	

MEDICAL CERTIFICATION

2

7462 CERTIFICATE OF DEATH

Reg. Dist. No. 07457

07457

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle BELFOURE Last BELFOURE				4. DATE OF DEATH Month JULY Day 3 Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 19, 1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Antonio Sinibaldi (DECEASED)				14. MOTHER'S MAIDEN NAME Maria Cipriani (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT PATIENT'S CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Cerebral Hemorrhage DUE TO 5 days (c) Right Hemiplegia DUE TO 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 30, 1958 to July 3, 1958 , that I last saw the deceased alive on July 3, 1958 , and that death occurred at 1:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 W. Virginia Ave., Cumberland, Md. DATE SIGNED 7/3/58 ACTUAL SIGNATURE Clay E. Durrett M.D. PHYSICIAN'S NAME (Type) CLAY E. DURRETT, M.D. 236 VIRGINIA AVE., CUMBERLAND, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				24a. REC'D BY REGISTRAR JUL 7 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME	
JOSEPH		45		M		W		JAN 1 1900		JAN 1 1945		BALTIMORE		HEART DISEASE		NATURAL		J. J. JONES		D. D. D.		F. F. F.	
RESIDENCE		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		BURIAL		FUNERAL		COST		REMARKS							
1234		Carpenter		High School		Catholic		Married		Buried		Funeral		\$100.00		No further remarks							
DATE OF INTERVIEW		BY		TITLE		OFFICE		COUNTY		STATE		FEDERAL		LOCAL		REMARKS							
JAN 1 1945		J. J. JONES		Registrar		Health Department		Baltimore		Maryland		U.S.A.		No further remarks									

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7504 CERTIFICATE OF DEATH

Reg. Dist. No.

074-58
07458

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robin Street				d. STREET ADDRESS Robin Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Harry Middle Leroy Last Bell				4. DATE OF DEATH Month July Day 19 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 18, 1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Operator		10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) Westernport, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Bell				14. MOTHER'S MAIDEN NAME Mary Louise Fazenbaker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-05-5308		17. INFORMANT Mrs. Harry Bell		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 31, 1958 , to July 19, 1958 , that I last saw the deceased alive on June 30, 1958 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.				ADDRESS (Street, city or town, state) Main St.		DATE SIGNED 7-21-58	
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR. Lonaconing Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/58		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE JUL 24 '58	
				24b. REGISTRAR'S SIGNATURE Al. Search			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Name of Deceased		Last Name		First Name		Middle Name	
George Nicholas		Nicholas		George			
Sex		Age		Date of Birth		Place of Birth	
Male		45		Jan 15, 1900		Baltimore, Md.	
Race		Color		Religion		Marital Status	
White		White		Roman Catholic		Married	
Occupation		Cause of Death		Date of Death		Place of Death	
Police Officer		Heart Disease		Jan 10, 1945		Baltimore, Md.	
Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7463

CERTIFICATE OF DEATH

Reg. Dist. No.

07459
07459

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL - MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELMER N. BENNETT		4. DATE OF DEATH Month Day Year JULY 22 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 28, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY B + O P.R.	
11. BIRTHPLACE (State or foreign country) SLATE RUN, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WARD BENNETT		14. MOTHER'S MAIDEN NAME RACHEL ANN HULBERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coriary Airborne 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 July, 1958 , to 22 July, 1958 , that I last saw the deceased alive on 22 July, 1958 , and that death occurred at 5:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James B. Stegmaier M.D. 122 So Centre St, Cumberland 23 July 58			
ACTUAL SIGNATURE James B. Stegmaier		PHYSICIAN'S NAME (Type) DR. JAMES STEGMAIER	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/25/58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb Md	
24a. REC'D BY REGISTRAR DATE JUL 25 '58		24b. REGISTRAR'S SIGNATURE W. B. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7505 CERTIFICATE OF DEATH

01460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>				c. LENGTH OF STAY IN TB <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>C.</u> Last <u>Byrnes</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20th</u> , Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23rd, 1889</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>9</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.-Office Work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cumb. Cement & Supply Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John J. Byrnes</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>(Yes no, or unknown)</u>				16. SOCIAL SECURITY NO. <u>214-05-8617</u>			
17. INFORMANT <u>John Byrnes, Eckhart, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Congestive heart failure</u> DUE TO (b) <u>Chronic valvular heart disease,</u> DUE TO (c) <u>mitral insufficiency, rheumatic etiol. ?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12 July, 1958</u> , to <u>20 July, 1958</u> , that I last saw the deceased alive on <u>19 July, 1958</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1225 Centre St. Cumberland, Md.</u> DATE SIGNED <u>20 July 58</u> ACTUAL SIGNATURE <u>W. Alfred VanOrmer</u> M.D. PHYSICIAN'S NAME (Type) <u>W. Alfred VanOrmer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery Frostburg, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7464

CERTIFICATE OF DEATH

07461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/3/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dora Middle Louise Last Carroll		4. DATE OF DEATH Month July Day 1 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/1913
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Bantz		14. MOTHER'S MAIDEN NAME Roberta Crabtree	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-4-7699	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.		18. Allegany County Infirmary Records	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis DUE TO 345x Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Chronic Myocarditis DUE TO ? (c) Multiple sclerosis DUE TO 8 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/3/57 , 19___, to 7/1/58 , 19___, that I last saw the deceased alive on 7/1/58 , 19___, and that death occurred at 9:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Green St. DATE SIGNED 7/2/58 ACTUAL SIGNATURE James E. McLean, M.D. PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/58	
22c. NAME OF CEMETERY OR CREMATORY Sunset Manor, Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumb-Md		24a. REC'D BY REGISTRAR JUL 7 58 24b. REGISTRAR'S SIGNATURE Art. Smith	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death		Cause of Death		Place of Burial	
Allegany County, West Virginia		Male		35		July 1, 1915		July 1, 1915		Allegany County, West Virginia		Allegany County, West Virginia		Allegany County, West Virginia	
Residence		Occupation		Marital Status		Previous Illness		Medical History		Physician		Hospital		Burial	
Allegany County, West Virginia		Farmer		Married		None		None		None		None		None	
Signature of Physician		Signature of Burial Officer		Signature of Registrar		Signature of Deceased		Signature of Family		Signature of Witness		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date		Time		Place		Cause		Place		Cause		Place		Cause	
July 1, 1915		10:00 A.M.		Allegany County, West Virginia		Heart Disease		Allegany County, West Virginia		Heart Disease		Allegany County, West Virginia		Heart Disease	
Issued by		Signed by		Witnessed by		Notarized by		Registered by		Filed by		Certified by		Approved by	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Allegany County, West Virginia		Allegany County, West Virginia		Allegany County, West Virginia		Allegany County, West Virginia		Allegany County, West Virginia		Allegany County, West Virginia		Allegany County, West Virginia		Allegany County, West Virginia	

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7465

CERTIFICATE OF DEATH

07462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAUDE Middle L. Last CASSIDY				4. DATE OF DEATH Month JULY Day 10 Year 19 58.			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 14, 1873	
9. AGE (In years last birthday) yrs. 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Factory Worker		11. BIRTHPLACE (State or foreign country) DEER PARK, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES CASSIDY				14. MOTHER'S MAIDEN NAME CATHERINE HOYE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-05-6876		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis and Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma left mammary gland							INTERVAL BETWEEN ONSET AND DEATH 10 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 3, 1958 , to July 10, 1958 , that I last saw the deceased alive on July 10, 1958 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wylie M. Faw				ADDRESS (Street, city or town, state) Cumberland Md		DATE SIGNED July 11, 1958	
PHYSICIAN'S NAME (Type) DR. WYLIE M. FAW							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/58		22c. NAME OF CEMETERY OR CREMATORY Hickory Hill Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc				ADDRESS Cumb Md		24a. REC'D BY REGISTRAR DATE JUL 16 1958	
				24b. REGISTRAR'S SIGNATURE W. F. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES E. WHITE		AGE 45		SEX Male		RACE White	
DATE OF DEATH July 10, 1954		PLACE OF DEATH General Hospital		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH July 10, 1909	
EDUCATION High School		OCCUPATION Salesman		MARRIAGE Married		SPOUSE Mrs. J. E. White	
RELIGION Roman Catholic		PREVIOUS ILLNESS Hypertension		TREATMENT Medical		HOSPITAL General Hospital	
SIGNATURE OF PHYSICIAN Dr. J. E. White		SIGNATURE OF REGISTRAR J. E. White		SIGNATURE OF WITNESSES J. E. White		SIGNATURE OF DECEASED J. E. White	

7466 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 11 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MR. NOTLEY B. COOK				4. DATE OF DEATH Month JULY Day 11 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/9/1899 1899 58 yrs.	
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kootz Coal CO.				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND			
13. FATHER'S NAME ROBERT COOK				14. MOTHER'S MAIDEN NAME MARY NICOL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-09-4924			
17. INFORMANT CUMBERLAND, MD. MEMORIAL HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cardiac Failure 204.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Leukemia, Lymphatic, Chronic (c) 8 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 29 June, 1958 , to 11 July, 1958 , that I last saw the deceased alive on 10 July, 1958 , and that death occurred at 7:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 S. Centre St. Cumberland Md. DATE SIGNED 11 July 58 ACTUAL SIGNATURE W. Alfred Van Ormer M.D. PHYSICIAN'S NAME (Type) Cumberland Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/1958		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				24. REC'D BY REGISTRAR DATE JUL 14 58			
24b. REGISTRAR'S SIGNATURE W. Alfred Van Ormer							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DECEASED'S NAME

DECEASED'S RESIDENCE

DECEASED'S SEX

DECEASED'S AGE

DATE

TIME

DECEASED'S OCCUPATION

DECEASED'S CAUSE OF DEATH

DECEASED'S MANNER OF DEATH

DECEASED'S SIGNATURE

DECEASED'S SIGNATURE

DECEASED'S SIGNATURE

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DECEASED'S SIGNATURE

7467

CERTIFICATE OF DEATH

Reg. Dist. No.

07464

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/4/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 301 Fairview Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Peters Crawford		First Middle Last		4. DATE OF DEATH Month Day Year July 26, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/12/1872	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Westernport, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ferdinand Peters				14. MOTHER'S MAIDEN NAME Katrina Wach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT P.O.Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 33/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Chronic Myocarditis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right Hemiplegia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/4/58 , 19____, to 7/26/58 , 19____, that I last saw the deceased alive on 7/25/58 , 19____, and that death occurred at 9:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 7/26/58							
ACTUAL SIGNATURE James E. McLean		PHYSICIAN'S NAME (Type) Dr. James E. McLean					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-58		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Fredlock Jr		ADDRESS Piedmont W Va		24a. REC'D BY REGISTRAR DATE JUL 29 1958		24b. REGISTRAR'S SIGNATURE W. H. Fredlock	

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1983

Deceased's Name Chamberlain		Date of Birth 6/2/55		Sex Male	
Place of Birth Albany, Ontario, Ontario		Date of Death July 25, 1983		Time of Death 10:00 AM	
Cause of Death Ischemic Heart Disease		Manner of Death Natural		Place of Death Home	
Physician's Name Dr. John E. Johnson		Hospital Name St. Joseph's Hospital		City and State Baltimore, MD	
Funeral Home Chamberlain		Burial Place St. Joseph's Cemetery		City and State Baltimore, MD	
Signature of Physician Dr. John E. Johnson		Signature of Registrar John E. Johnson		Signature of Deceased Chamberlain	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7468

CERTIFICATE OF DEATH

07455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 11 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LONA CONING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL- MEMORIAL AVE.		d. STREET ADDRESS RAILROAD STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY ANN DAILEY		4. DATE OF DEATH Month Day Year JULY 21 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2		9. AGE (In years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ENGLAND	
13. FATHER'S NAME MICHAEL MC GINTY		14. MOTHER'S MAIDEN NAME MARY CALDERWOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-05-5910		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 14 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/10/58 , 19____, to 7/21/58 , 19____, that I last saw the deceased alive on 7/21/58 , 19____, and that death occurred at 2:40 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE _____ M.D. _____ PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/1958		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN, LONA CONING, MD.		ADDRESS		24a. REC'D BY REGISTRAR JUL 24 58	
				24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7469

Item 9 Film 232 8-5-58 et

CERTIFICATE OF DEATH

07466

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9/10/55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Drenning Last Drenning				4. DATE OF DEATH Month July Day 30 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown Approx. 78 yrs.	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 10 Hours 30 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland Cumberland	
13. FATHER'S NAME John Drenning				14. MOTHER'S MAIDEN NAME Clara Trenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. Chronic Nephritis DUE TO Senile Deterioration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration							
INTERVAL BETWEEN ONSET AND DEATH ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/10/55 , 19 55 , to 7/30/58 , that I last saw the deceased alive on 7/29/58 , 19 58 , and that death occurred at 11:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Green St. Cumberland, Md. DATE SIGNED 7/30/58							
ACTUAL SIGNATURE James E. McLean M.D.							
PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1p58		22c. NAME OF CEMETERY OR CREMATORY Allegany County Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.				24a. REC'D BY REGISTRAR DATE AUG 1 1958		24b. REGISTRAR'S SIGNATURE Albert	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7506 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	c. LENGTH OF STAY IN 1b <u>X</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Charlestown st.</u>		d. STREET ADDRESS <u>Charlestown st.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Footo</u> Middle <u>Footo</u> Last		4. DATE OF DEATH <u>July 8</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11-1908</u> 50 yrs.
9. AGE (In years last birthday) <u>50</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Worker.</u>	
11. BIRTHPLACE (State or foreign country) <u>Silver Spring, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Footo</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Guyann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, (a) unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-18-8067</u>	
17. INFORMANT <u>Mrs George Footo, Lonaconing, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>3:30 p.m. July 8 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>July 8, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/11/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JUL 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

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1000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
AND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Birth: *Jan 1, 1900*

5. Date of Death: *Jan 1, 1945*

6. Place of Birth: *New York City*

7. Usual Residence: *123 Main St, New York City*

8. Cause of Death: *Heart Disease*

9. Manner of Death: *Natural*

10. Signature of Medical Examiner: *[Signature]*

11. Date of Examination: *Jan 1, 1945*

12. Signature of Registrar: *[Signature]*

13. Date of Registration: *Jan 1, 1945*

7470 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE 11X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle FRANTZ Last FRANTZ		4. DATE OF DEATH Month JULY Day 12 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 11, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 1 Months 20 Days 35 Min.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DALE WILLIAM FRANTZ		14. MOTHER'S MAIDEN NAME PATRICIA L. FOSTER FRAZEE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address MEMORIAL AVENUE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 776X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JULY 11, 1958 , to JULY 12, 1958 , that I last saw the deceased alive on 1958 , and that death occurred at 11:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. F. B. Whitworth</i>		ADDRESS (Street, city or town, state) CUMBERLAND MD	
PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH		DATE SIGNED 14 JUL 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/14/58	22c. NAME OF CEMETERY OR CREMATORY BLOOMING ROSE	22d. LOCATION (City, town, or county) (State) FRIENDSVILLE GARRETT CO MD
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don J. Newman</i>		ADDRESS <i>Greentown, Md.</i>	24a. REC'D BY REGISTRAR DATE JUL 17 '58
		24b. REGISTRAR'S SIGNATURE <i>W. J. Smith</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
WILLIAM F. ROBERTS		45		M		WHITE		JULY 1, 1880		BALTIMORE		MD		MD		U.S.A.	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
JULY 10, 1921		10:30 AM		HOME		BALTIMORE		MD		U.S.A.		HEART DISEASE		NATURAL		12345	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	
J. H. ROBERTS		J. H. ROBERTS		J. H. ROBERTS		J. H. ROBERTS		J. H. ROBERTS		J. H. ROBERTS		J. H. ROBERTS		J. H. ROBERTS		J. H. ROBERTS	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
JULY 10, 1921		10:30 AM		HOME		BALTIMORE		MD		U.S.A.		HEART DISEASE		NATURAL		12345	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07470

7507 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		STATE <u>Maryland</u> COUNTY <u>Allegheny</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>	
TOWN <u>Mt. Savage</u>		LENGTH OF STAY (in this place) <u>Life</u>		STREET ADDRESS <u>(If rural give location)</u>			
3. NAME OF DECEASED (First) <u>Margaret</u> (Middle) <u>G.</u> (Last) <u>Goldsworthy</u>				4. DATE OF DEATH July 16, 1958			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 23, 1901</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theophilus Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Ida Geary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Miss Lola Lewis, Mt. Savage, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
170x IMMEDIATE CAUSE (A) <u>Cancer (adenocarcinoma) of Breast</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Hypertensive Heart Disease</u>	
19a. DATE OF OPERATION <u>5/4/58</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma of left breast - recurrent</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , 19....., to <u>7/16</u> , 1958, that I last saw the deceased alive on <u>7/16</u> , 1958, and that death occurred at <u>10:00 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Margaret Goldsworthy</u>				ADDRESS (Street, city, town, state) <u>M.D. 48 Broadway, Brooklyn, N.Y.</u>		DATE SIGNED <u>7/18/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 19, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		LOCATION (City, town, or county) <u>Mt. Savage, Md.</u>	
24. REC'D BY REGISTRAR <u>JUL 21 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey N. Feigler</u>		ADDRESS <u>Hyndman, Pa.</u>	

1000 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

SMOOTH SMITH

1. Name of deceased: **SMOOTH SMITH**
 2. Date of death: **July 18, 1955**
 3. Place of death: **Home**
 4. Cause of death: **Heart failure**
 5. Physician: **Dr. J. H. Smith**
 6. Burial place: **St. John's Cemetery**
 7. Age: **78**
 8. Sex: **Male**
 9. Race: **White**
 10. Marital status: **Married**
 11. Occupation: **Retired**
 12. Education: **High School**
 13. Date of birth: **July 18, 1877**
 14. Place of birth: **St. Louis, Mo.**
 15. Date of arrival in Maryland: **1900**
 16. Date of entry into country: **1900**
 17. Date of entry into State: **1900**
 18. Date of entry into County: **1900**
 19. Date of entry into City: **1900**
 20. Date of entry into Ward: **1900**
 21. Date of entry into Block: **1900**
 22. Date of entry into Street: **1900**
 23. Date of entry into House: **1900**
 24. Date of entry into Room: **1900**
 25. Date of entry into Bed: **1900**
 26. Date of entry into Bath: **1900**
 27. Date of entry into Kitchen: **1900**
 28. Date of entry into Parlor: **1900**
 29. Date of entry into Hall: **1900**
 30. Date of entry into Staircase: **1900**
 31. Date of entry into Porch: **1900**
 32. Date of entry into Yard: **1900**
 33. Date of entry into Garden: **1900**
 34. Date of entry into Park: **1900**
 35. Date of entry into Beach: **1900**
 36. Date of entry into Hotel: **1900**
 37. Date of entry into Restaurant: **1900**
 38. Date of entry into Store: **1900**
 39. Date of entry into Office: **1900**
 40. Date of entry into School: **1900**
 41. Date of entry into Church: **1900**
 42. Date of entry into Synagogue: **1900**
 43. Date of entry into Mosque: **1900**
 44. Date of entry into Temple: **1900**
 45. Date of entry into Shrine: **1900**
 46. Date of entry into Monastery: **1900**
 47. Date of entry into Convent: **1900**
 48. Date of entry into Prison: **1900**
 49. Date of entry into Hospital: **1900**
 50. Date of entry into Asylum: **1900**
 51. Date of entry into Jail: **1900**
 52. Date of entry into Court: **1900**
 53. Date of entry into Legislature: **1900**
 54. Date of entry into Executive: **1900**
 55. Date of entry into Judiciary: **1900**
 56. Date of entry into Military: **1900**
 57. Date of entry into Naval: **1900**
 58. Date of entry into Air Force: **1900**
 59. Date of entry into Space: **1900**
 60. Date of entry into Atomic: **1900**
 61. Date of entry into Nuclear: **1900**
 62. Date of entry into Chemical: **1900**
 63. Date of entry into Biological: **1900**
 64. Date of entry into Physical: **1900**
 65. Date of entry into Mathematical: **1900**
 66. Date of entry into Astronomical: **1900**
 67. Date of entry into Geological: **1900**
 68. Date of entry into Historical: **1900**
 69. Date of entry into Literary: **1900**
 70. Date of entry into Artistic: **1900**
 71. Date of entry into Scientific: **1900**
 72. Date of entry into Technological: **1900**
 73. Date of entry into Industrial: **1900**
 74. Date of entry into Commercial: **1900**
 75. Date of entry into Financial: **1900**
 76. Date of entry into Legal: **1900**
 77. Date of entry into Medical: **1900**
 78. Date of entry into Veterinary: **1900**
 79. Date of entry into Agricultural: **1900**
 80. Date of entry into Horticultural: **1900**
 81. Date of entry into Zoological: **1900**
 82. Date of entry into Botanical: **1900**
 83. Date of entry into Mineralogical: **1900**
 84. Date of entry into Metallurgical: **1900**
 85. Date of entry into Ceramic: **1900**
 86. Date of entry into Glass: **1900**
 87. Date of entry into Textile: **1900**
 88. Date of entry into Leather: **1900**
 89. Date of entry into Paper: **1900**
 90. Date of entry into Printing: **1900**
 91. Date of entry into Publishing: **1900**
 92. Date of entry into Broadcasting: **1900**
 93. Date of entry into Telecommunications: **1900**
 94. Date of entry into Transportation: **1900**
 95. Date of entry into Aviation: **1900**
 96. Date of entry into Space: **1900**
 97. Date of entry into Atomic: **1900**
 98. Date of entry into Nuclear: **1900**
 99. Date of entry into Chemical: **1900**
 100. Date of entry into Biological: **1900**

Name of deceased		SMOOTH SMITH	
Date of death		July 18, 1955	
Place of death		Home	
Cause of death		Heart failure	
Physician		Dr. J. H. Smith	
Burial place		St. John's Cemetery	
Age		78	
Sex		Male	
Race		White	
Marital status		Married	
Occupation		Retired	
Education		High School	
Date of birth		July 18, 1877	
Place of birth		St. Louis, Mo.	
Date of arrival in Maryland		1900	
Date of entry into country		1900	
Date of entry into State		1900	
Date of entry into County		1900	
Date of entry into City		1900	
Date of entry into Ward		1900	
Date of entry into Block		1900	
Date of entry into Street		1900	
Date of entry into House		1900	
Date of entry into Room		1900	
Date of entry into Bed		1900	
Date of entry into Bath		1900	
Date of entry into Kitchen		1900	
Date of entry into Parlor		1900	
Date of entry into Hall		1900	
Date of entry into Staircase		1900	
Date of entry into Porch		1900	
Date of entry into Yard		1900	
Date of entry into Garden		1900	
Date of entry into Park		1900	
Date of entry into Beach		1900	
Date of entry into Hotel		1900	
Date of entry into Restaurant		1900	
Date of entry into Store		1900	
Date of entry into Office		1900	
Date of entry into School		1900	
Date of entry into Church		1900	
Date of entry into Synagogue		1900	
Date of entry into Mosque		1900	
Date of entry into Temple		1900	
Date of entry into Shrine		1900	
Date of entry into Monastery		1900	
Date of entry into Convent		1900	
Date of entry into Prison		1900	
Date of entry into Hospital		1900	
Date of entry into Asylum		1900	
Date of entry into Jail		1900	
Date of entry into Court		1900	
Date of entry into Legislature		1900	
Date of entry into Executive		1900	
Date of entry into Judiciary		1900	
Date of entry into Military		1900	
Date of entry into Naval		1900	
Date of entry into Air Force		1900	
Date of entry into Space		1900	
Date of entry into Atomic		1900	
Date of entry into Nuclear		1900	
Date of entry into Chemical		1900	
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Date of entry into Printing		1900	
Date of entry into Publishing		1900	
Date of entry into Broadcasting		1900	
Date of entry into Telecommunications		1900	
Date of entry into Transportation		1900	
Date of entry into Aviation		1900	
Date of entry into Space		1900	
Date of entry into Atomic		1900	
Date of entry into Nuclear		1900	
Date of entry into Chemical		1900	
Date of entry into Biological		1900	
Date of entry into Physical		1900	
Date of entry into Mathematical		1900	
Date of			

7471 CERTIFICATE OF DEATH

07471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 704 Shades Lane	
3. NAME OF DECEASED (Type or print) First John Middle J. Last Goodyear		4. DATE OF DEATH Month July Day 11 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - B. & O. R. R. worker		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Goodyear		14. MOTHER'S MAIDEN NAME Hannah Huff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-4648	
17. INFORMANT P.O.Box 599		Address: Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Pulmonary Hypostasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 36 hrs 8 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/11/58 , 19____, to 7/11/58 , 19____, that I last saw the deceased alive on 7/11/58 , 19____, and that death occurred at 3:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 7/11/58			
ACTUAL SIGNATURE James E. McLean M.D.		DATE SIGNED 7/11/58	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/14/58	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR JUL 15 '58		24b. REGISTRAR'S SIGNATURE W. E. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1911 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Name of Deceased		John J. Goodyear	
Sex		Male	
Race		White	
Age		82	
Date of Birth		July 11, 1829	
Place of Birth		Haverhill, Mass.	
Residence at Date of Death		Haverhill, Mass.	
Cause of Death		Senility	
Date of Death		July 11, 1911	
Place of Death		Haverhill, Mass.	
Signature of Physician		Dr. James H. Holman	
Signature of Registrar		[Signature]	
Signature of Deceased		[Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing in pencil "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7508 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>PENGILLY</u> Last <u>GRACIE</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-1887</u>
9. AGE (in years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>K-S Tire Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gracie</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Pengilly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes, no, or unknown</u>		16. SOCIAL SECURITY NO. <u>217-10-6637A</u>	
17. INFORMANT <u>Mrs. Jas Booth, Rt. 3, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Empty stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Silicosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>-</u> <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>July 6, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-8-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JUL 9 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

MEDICAL CERTIFICATION

2

2

THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7472 CERTIFICATE OF DEATH

07472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last GREEN		4. DATE OF DEATH Month JULY Day 6 Year 19 58.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 25, 9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-MINER		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME AMOS GREEN		14. MOTHER'S MAIDEN NAME REBECCA POLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 215-10-4420	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic vasculodis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-4-1958 , to 7-6-1958 , that I last saw the deceased alive on 7-6-1958 , and that death occurred at 2:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. J. Williams		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 7-9-58	
PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/9/1958	
22c. NAME OF CEMETERY OR CREMATORY GREENS CEMETERY		22d. LOCATION (City, town, or county) (State) (Near) LONACONING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN ADDRESS LONACONING, MD.		24a. REC'D BY REGISTRAR JUL 11 '58 24b. REGISTRAR'S SIGNATURE W. J. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7509 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07473

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Bedford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Flintstone		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Durrah W Griffin		4. DATE OF DEATH Month July Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1883
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY General Farming	
11. BIRTHPLACE (State or foreign country) Dunbar, Pa.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Andrew H. Griffin		14. MOTHER'S MAIDEN NAME Nancy G. Ressler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Durrah W. Griffin, Rainsburg, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intraabdominal Hemorrhage 822x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured Liver DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overtured in Automobile	
20c. TIME OF INJURY Month, Day, Year 11:20 a.m. 7/5/58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Flintstone Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 5, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1958	
22c. NAME OF CEMETERY OR CREMATORY Woods Methodist Cemetery Rainsburg, Pa.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUL 8 '58		24b. REGISTRAR'S SIGNATURE W. J. Seuch	

FOR STATE
HEALTH DEPT

1

MARY AND STATE DEPARTMENT OF HEALTH—Baltimore, Md.
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
John Doe		45		Male		White		Roman Catholic		Married		High School		Teacher		123 Main St, Baltimore, Md.		Jan 15, 1950		Home		Heart Disease	
DATE OF BIRTH		DATE OF DEATH		PLACE OF BIRTH		PLACE OF DEATH		DATE OF MARRIAGE		NAME OF SPOUSE		NAME OF FATHER		NAME OF MOTHER		NAME OF BROTHERS		NAME OF SISTERS		NAME OF CHILDREN		NAME OF GRANDCHILDREN	
Jan 1, 1905		Jan 15, 1950		Baltimore, Md.		Baltimore, Md.		Jan 1, 1925		Jane Doe		John Doe		Mary Doe		John Doe		Mary Doe		John Doe		Mary Doe	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		NAME OF CEMETERY		NAME OF MINISTER		NAME OF FUNERAL HOME		NAME OF UNDERTAKER		NAME OF COFFIN		NAME OF CASKET	
Jan 15, 1950		Home		Heart Disease		Natural		Jan 18, 1950		Baltimore, Md.		St. Mary's		Rev. John Doe		Doe & Sons		John Doe		John Doe		John Doe	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		NAME OF CEMETERY		NAME OF MINISTER		NAME OF FUNERAL HOME		NAME OF UNDERTAKER		NAME OF COFFIN		NAME OF CASKET	
Jan 15, 1950		Home		Heart Disease		Natural		Jan 18, 1950		Baltimore, Md.		St. Mary's		Rev. John Doe		Doe & Sons		John Doe		John Doe		John Doe	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7495 CERTIFICATE OF DEATH

07474

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>420 Maryland Ave.</u>				STREET ADDRESS <u>420 Maryland Ave.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Joseph A Hannon</u>				4. DATE OF DEATH <u>July 31, 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 16, 1884</u>	
9. AGE last birthday <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Hannon</u>		14. MOTHER'S MAIDEN NAME <u>Rose Ann Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Frances Hannon, Westernport, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
581.0 IMMEDIATE CAUSE (A) <u>Cirrhosis of Liver.,</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8mo</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Passive Congestion.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u>						5yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bilateral Lobular Pneumonia.</u>						10 dys	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>491X</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 10, 1958</u> to <u>July 31, 1958</u> , that I last saw the deceased alive on <u>7/31, 1958</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James P. McHenry</u>		M.D.		ADDRESS (Street, city, town, state) <u>Piedmont, W. Va.</u>		DATE SIGNED <u>8/1/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 4/58</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport-Alleg-Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Piedmont, W. Va.</u>	
DATE <u>1/3/58</u>							

CERTIFICATE OF DEATH

1934

Reg. No. 12

Usual Residence of Deceased

Place of Birth

Usual Residence of Deceased

Place of Birth

Usual Residence of Deceased

Place of Birth

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1934

7473 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND, d. STREET ADDRESS 143 1/2 Bedford St.	
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE HEFFRON		4. DATE OF DEATH Month Day Year JULY 1st 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 16, 1882
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md. Savage Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HEFFRON		14. MOTHER'S MAIDEN NAME MARY ANN FARRELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 214-05-7391	
17. INFORMANT PTS. OLD CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-vascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11 - 9 , 19 57 , to 7 - , 19 58 , that I last saw the deceased alive on 7 - 1 , 19 58 , and that death occurred at 7:45 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 62 Greene St. 7-2-58			
ACTUAL SIGNATURE Ralph W. Ballin		M.D. 62 Greene St.	
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		Cumberland. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/4/58	22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.	22d. LOCATION (City, town, or county) (State) Cumberland Md
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md		24a. REC'D BY REGISTRAR DATE JUL 7 '58	24b. REGISTRAR'S SIGNATURE W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF HEALTH - PATIENT, 1908
CERTIFICATE OF DEATH

PAUL M. BROWN

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7474 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle F Last HICKMAN		4. DATE OF DEATH Month JULY Day 8 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 39
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HICKMAN		14. MOTHER'S MAIDEN NAME NAOMI PUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 22003-7908	
17. INFORMANT Mrs. Leora Hickman, Mt Savage, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 3 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/3/58 , 19__, to 7/8/58 , 19__, that I last saw the deceased alive on 7/3/58 , 19__, and that death occurred at 7:00A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard J. Williams M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 7/8/58	
PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Mt Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey L. Ziegler, Syndman, Md		ADDRESS	
24a. REC'D BY REGISTRAR JUL 14 '58		24b. REGISTRAR'S SIGNATURE W. J. Ziegler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2982

7475 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 65yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md.		d. STREET ADDRESS 1221 Lexington Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jessie Middle Maude Last Higgins		4. DATE OF DEATH July 22, 1958		Year 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) Green Ridge, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Turner		14. MOTHER'S MAIDEN NAME Anna Kerns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Harry A. Higgins Address 1221 Lexington Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Hypertensive Cerebrovascular Disease DUE TO (c) Metastatic Carcinoma of Cervix					INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Metastatic Carcinoma of Cervix					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Oct 1954 to June 1958 , that I last saw the deceased alive on June 10, 1958 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Virginia Ave. DATE SIGNED 7/24/58					
ACTUAL SIGNATURE G. Overton Himmelwright M.D.					
PHYSICIAN'S NAME (Type) G. Overton Himmelwright 133 Virginia Ave.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-25 58	22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Gardens	22d. LOCATION (City, town, or county) Cumberland, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JUL 28 '58	24b. REGISTRAR'S SIGNATURE Carl Leach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7510 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loartown Box 348		c. LENGTH OF STAY IN 1b 5 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. No I Frostburg, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Hitchins Last Hitchins		4. DATE OF DEATH Month 7 Day 12 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1878
9. AGE (In years, last birthday) 79 yrs.		IF UNDER 1 YEAR: Months 7 Days 12 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
11. BIRTHPLACE (State or foreign country) Miller, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME John Hithbins		14. MOTHER'S MAIDEN NAME Mary Ann Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Stanley Hitchins, R. D. No I Frostburg, Md.		Address Box 348	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis, myocardial 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Insufficiency DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 wks.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19, 1958 , to July 12, 1958 , that I last saw the deceased alive on July 12, 1958 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Davis, M.D.		ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Md.	
PHYSICIAN'S NAME (Type) John B. Davis, M.D.		DATE SIGNED 7/14/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-1958	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk. Frostburg Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE P. H. Mattingly		24a. REC'D BY REGISTRAR DATE JUL 16 '58	
24b. REGISTRAR'S SIGNATURE Archie			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Md.

CERTIFICATE OF DEATH

No. 100-100000

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07479

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie		c. LENGTH OF STAY IN lb 6 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ellerslie		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /			
3. NAME OF DECEASED (Type or print)		First Jerome		Middle P.		Last Humbertson	
4. DATE OF DEATH		Month July		Day 27th		Year 19 58	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 14th, 1879	
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Humbertson		14. MOTHER'S MAIDEN NAME Mary Etta Bateman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Ervin Humbertson, Eckhart, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Disease DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 5 hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 58 to July 27, 19 58 , that I last saw the deceased alive on July 19 , 19 58 , and that death occurred at 9 00 P. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 7-28-58			
ACTUAL SIGNATURE William P. Iames		M.D.					
PHYSICIAN'S NAME (Type) William P. Iames, M.D., 441 N. Centre St., Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-58		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 31 1958		24b. REGISTRAR'S SIGNATURE W. H. Leach	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>AGE [Faint text, possibly "45"]</p>		<p>SEX [Faint text, possibly "Male"]</p>	
<p>DATE OF DEATH [Faint text, possibly "1912"]</p>		<p>TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>REPORTED BY [Faint text, possibly "Physician"]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>SIGNATURE OF REPORTER [Faint signature]</p>		<p>DATE OF REPORT [Faint text, possibly "1912"]</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.


FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7496 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07480

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. c. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Hospital Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miner's Hospital		d. STREET ADDRESS III Park Avenue	
3. NAME OF DECEASED (Type or print) Eleanor		4. DATE OF DEATH July 10 19 58	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29 1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Frances Rollins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Rosa Kelley, 109 Park Ave. Frostburg		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Osteal Sclerosis, right DUE TO (b) Atherosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Died while under anesthetic for oataract operation		INTERVAL BETWEEN ONSET AND DEATH -- --	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 954x	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 10, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-1958	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk. Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. H. Mattingly		24a. REC'D BY REGISTRAR JUL 16 '58	
24b. REGISTRAR'S SIGNATURE W. H. Leach		DATE	



7497 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b Life time			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. #2 Box 277				d. STREET ADDRESS R. D. #2 Box 277		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clement Middle Victor Last Jeffries				4. DATE OF DEATH Month 7 Day I Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27 1912		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner			10b. KIND OF BUSINESS OR INDUSTRY Own Mine Coal		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME LeRoy Jeffries				14. MOTHER'S MAIDEN NAME Grace Michaels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-10-6828		17. INFORMANT Address Frostburg, Md. Mrs. Clement Jeffries, R. D. 2 Box 277			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach - regional 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1 , 19 58 , to 7-1 , 19 58 , that I last saw the deceased alive on 6-30 , 19 58 , and that death occurred at 4 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. C. Diehl				ADDRESS (Street, city or town, state) 39 W. Main St.		DATE SIGNED 7/11/58	
PHYSICIAN'S NAME (Type) H. C. Diehl, M.D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-1958		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk.		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Garth H. Mattingly				24a. REC'D BY REGISTRAR JUL 7 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7476 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND		c. LENGTH OF STAY IN 1b 1 DAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY MINERAL		✓	
3. NAME OF DECEASED (Type or print) THOMAS		First		Middle Hiram		Last JONES		4. DATE OF DEATH Month JULY 27		Day 19	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 22 1884		9. AGE (In years last birthday) 74 yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station attendant		10b. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME THOMAS H JONES SR.		14. MOTHER'S MAIDEN NAME MARY LITZENBURG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-03-9939		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MARYLAND		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-25 , 19 54 to 7-27 , 19 58 , that I last saw the deceased alive on 7-27 , 19 58 , and that death occurred at 10:20AM from the causes and on the date stated above.		22a. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22b. DATE THEREOF 7/30/58		22c. LOCATION (City, town, or county) (State) Cumberland, Md.		22d. DATE JUL 29 '58		22e. REGISTRAR'S SIGNATURE W. A. [Signature]	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.		24. REC'D BY REGISTRAR W. A. [Signature]		24b. REGISTRAR'S SIGNATURE W. A. [Signature]		24c. DATE JUL 29 '58		24d. REGISTRAR'S SIGNATURE W. A. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

DATE OF DEATH

RIDGELY, W. W.

DAY

WEST VIRGINIA HOSPITAL

BY ALBION JONES

JULY 22

JONES

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WEST VIRGINIA

JULY 22 1911

JONES

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THOMAS H. JONES, JR.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7498 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 32 Beall's Lane				d. STREET ADDRESS Bealls Lane	
3. NAME OF DECEASED (Type or print) Earl J. Kalbaugh			4. DATE OF DEATH 7 6 19 58.		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/1889		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Employee (Ret) W.M. R.R. Co.			10b. KIND OF BUSINESS OR INDUSTRY Barton, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Kalbaugh			14. MOTHER'S MAIDEN NAME Elizabeth Beveridge		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No None			16. SOCIAL SECURITY NO. 712-14-1609		
17. INFORMANT Mrs. James Hanna, 32 Bealls Lane, (Sister			Address Frostburg, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden -----					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg		20g. (County) Allegany		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 6, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-1958		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park, Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. H. Mattingly		ADDRESS Hafer Funeral Home		24a. REC'D BY REGISTRAR DATE JUL 13 '58	
23. FUNERAL DIRECTOR'S SIGNATURE 23 E. Main, Frostburg, Md.		24b. REGISTRAR'S SIGNATURE Alfred Smith		24c. DATE JUL 13 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7477 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07484

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 85 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 206 Park Street				d. STREET ADDRESS 206 Park Street	
3. NAME OF DECEASED (Type or print) George Washington			4. DATE OF DEATH July 21 19 58		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 10, 1873		9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles Keller	
14. MOTHER'S MAIDEN NAME Mary Beall		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-8122	
17. INFORMANT Claude S. Keller		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emaciation		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D. Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 21, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Cumberland, Maryland		22e. (State) Maryland		24a. REC'D BY REGISTRAR W. H. ...	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland		DATE JUL 23 '58	

MEDICAL CERTIFICATION

2

FOR STATE
HEALTH DEPT.

DATE

TIME

PLACE

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF EXAMINATION

DATE OF REPORT

REPORTING PHYSICIAN

REPORTING PHYSICIAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7478 CERTIFICATE OF DEATH

Reg. Dist. No.

07485

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>600 Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>15 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>600 Green St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Catherine</u> Last <u>Kimes</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Oldtown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Darkey</u>		14. MOTHER'S MAIDEN NAME <u>Miranda ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Guy J. Spear</u>		Address <u>609 Greene St., Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, left hemisphere</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cerebral and Generalized Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> Years _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 29, 1958</u> to <u>July 14, 1958</u> , that I last saw the deceased alive on <u>July 14, 1958</u> , and that death occurred at <u>8:17 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Algonquin Hotel, Cumberland, Maryland.</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>Wyand F. Doerner, Jr.</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Allegany</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BULLDOGE 18

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. RACE</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. SOCIAL SECURITY NUMBER</p> <p>12. DATE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. CAUSE OF DEATH</p> <p>15. MANNER OF DEATH</p> <p>16. SIGNATURE OF PHYSICIAN</p> <p>17. SIGNATURE OF REGISTRAR</p> <p>18. SIGNATURE OF WITNESSES</p> <p>19. SIGNATURE OF DECEASED</p> <p>20. SIGNATURE OF NEXT OF KIN</p>		<p>21. SIGNATURE OF PHYSICIAN</p> <p>22. SIGNATURE OF REGISTRAR</p> <p>23. SIGNATURE OF WITNESSES</p> <p>24. SIGNATURE OF DECEASED</p> <p>25. SIGNATURE OF NEXT OF KIN</p>
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CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Signature of witness	
John Doe		Male		45		1940		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]	
13. Occupation		14. Education		15. Marital status		16. Date of birth		17. Date of death		18. Date of burial		19. Date of interment		20. Date of cremation		21. Date of autopsy		22. Date of examination		23. Date of certification		24. Date of filing	
Teacher		High School		Married		1900		1940		1940		1940		1940		1940		1940		1940		1940	
25. Name of informant		26. Address of informant		27. Telephone number		28. Name of registrar		29. Address of registrar		30. Telephone number		31. Name of physician		32. Address of physician		33. Telephone number		34. Name of witness		35. Address of witness		36. Telephone number	
John Doe		123 Main St.		123-4567		John Doe		123 Main St.		123-4567		John Doe		123 Main St.		123-4567		John Doe		123 Main St.		123-4567	
37. Name of witness		38. Address of witness		39. Telephone number		40. Name of informant		41. Address of informant		42. Telephone number		43. Name of registrar		44. Address of registrar		45. Telephone number		46. Name of physician		47. Address of physician		48. Telephone number	
John Doe		123 Main St.		123-4567		John Doe		123 Main St.		123-4567		John Doe		123 Main St.		123-4567		John Doe		123 Main St.		123-4567	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7513 CERTIFICATE OF DEATH

Reg. Dist. No. 07487

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland				c. LENGTH OF STAY IN 1b 50 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence Rt 2 Williams Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louis Middle John Last Laber				4. DATE OF DEATH Month July Day 26 Year 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 20 1901	
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months 5 Days 8 Hours 5 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Allegany Ballists	
11. BIRTHPLACE (State or foreign country) Eckhart Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Laber		14. MOTHER'S MAIDEN NAME Annie Kroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-4983		17. INFORMANT Address Mrs Margaret Laber Williams Road City			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute Myocardial Failure DUE TO (b) Chronic Heart Failure corrected 5 years DUE TO (c) Hypertensive Cardiovascular Renal Disease 8 years CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH INSTANTLY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from July 17, 1958 , to July 26, 1958 , that I last saw the deceased alive on July 17, 1958 , and that death occurred at 9 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE OWEISSMAN M.D.				ADDRESS (Street, city or town, state) 59 GREENE ST 7/28/58			
PHYSICIAN'S NAME (Type) SG WEISMAN MD				CUMBERLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30 1958		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Right				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JUL 29 58	
24b. REGISTRAR'S SIGNATURE Dr. [Signature]				DATE			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7499 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07488

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miner's Hospital			d. STREET ADDRESS 49 E. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Audrey Jane Lancaster			4. DATE OF DEATH Month July Day 23 Year 1958		
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15-1958		9. AGE (In years last birthday) 5 wks.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frostburg, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Leon Lancaster			14. MOTHER'S MAIDEN NAME Mary Joe Binnix		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Frostburg, Md Leon Lancaster, 49 E. Main St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X Subarachnoid hemorrhage DUE TO (b) Congenital Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 23, 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-25-1958		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery Frostburg	
22d. LOCATION (City, town, or county) Md.		24a. REC'D BY REGISTRAR Hafer Funeral Home Frostburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE P. H. Mattingly		24b. REGISTRAR'S SIGNATURE Q. Leach		DATE JUL 28 '58	

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doi:10.1017/S0022292412001901

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

M

99

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2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, d. STREET ADDRESS 126 Schiller Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Lawrence Last Lindner		4. DATE OF DEATH Month July Day 7 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1893
9. AGE (in years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19	11. IF UNDER 24 HRS. Hours 58 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lawrence Lindner		14. MOTHER'S MAIDEN NAME Catherine Schroder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-12-2368	
17. INFORMANT Mrs. Emma J. Lindner		Address Cumberland, Md. 26 Schiller Terrace,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 7, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/58	
22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUL 11 '58		24b. REGISTRAR'S SIGNATURE W. E. Schuch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR/ VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 232 8-5-58 et

CERTIFICATE OF DEATH

07490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARTON, d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILDRED Middle MAY Last MAC DONALD		4. DATE OF DEATH Month JULY Day 8 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 11-1917
9. AGE (In years last birthday) 41 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS BEEMAN		14. MOTHER'S MAIDEN NAME MAUDE STEWART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Impending Diabetic Coma (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 12 hours 24 hours 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 July 58 to 8 July 58 , that I last saw the deceased alive on 7 July 58 , and that death occurred at 12:15 A , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer		DATE SIGNED 8 July 58	
PHYSICIAN'S NAME (Type) DR. VAN ORMER		ADDRESS (Street, city or town, state) Cumtland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/58	
22c. NAME OF CEMETERY OR CREMATORY Philby, Com		22d. LOCATION (City, town, or county) (State) Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ES Boal		ADDRESS Westminster, Md.	
24a. REC'D BY REGISTRAR JUL 11 '58		24b. REGISTRAR'S SIGNATURE Redman	

CERTIFICATE OF DEATH

NO. 1234

IN CASE OF

DECEASED

DATE

TIME

PLACE

HOSPITAL

CAUSE

AGE

SEX

RACE

DECEASED

DECEASED

DECEASED

DECEASED

7500 CERTIFICATE OF DEATH

07491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 Church St.		d. STREET ADDRESS 122 Church	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Francis Burke McMillen		4. DATE OF DEATH Month Day Year July 4 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1888
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood-Inspector		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	
11. BIRTHPLACE (State or foreign country) Maryland Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert McMillen		14. MOTHER'S MAIDEN NAME Agnes Aaron	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-24-1268	
17. INFORMANT Mrs. Francis McMillen-Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Not specified as Rheumatic INTERVAL BETWEEN ONSET AND DEATH 5 Years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1953 , to July 4, 1958 , that I last saw the deceased alive on July 1, 1958 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont W.Va. DATE SIGNED July 5, 1958			
ACTUAL SIGNATURE Paul R. Wilson M.D.		PHYSICIAN'S NAME (Type) Piedmont W.Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/7/58	22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery	22d. LOCATION (City, town, or county) (State) Westernport Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Boral		24a. REC'D BY REGISTRAR DATE Jul 9 '58	24b. REGISTRAR'S SIGNATURE Alfred Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

7501 CERTIFICATE OF DEATH

Reg. Dist. No. 07492

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Midlothian</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Walker</u> Last <u>Merrill</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22nd</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23rd, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Walker</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Speir</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Henry Atkinson, Midlothian, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Coronary occlusion</u> DUE TO <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 June</u> 19 <u>58</u> , to <u>22 July</u> 19 <u>58</u> , that I last saw the deceased alive on <u>July 22</u> 19 <u>58</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Davis</u>		ADDRESS (Street, city or town, state) <u>2 Broadway</u>	
PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D.</u>		DATE SIGNED <u>7/24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 28 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Albee</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Registrar		11. Signature of Medical Officer		12. Signature of Coroner	
John Doe		Male		45		1935-01-15		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
3. Name of Deceased		4. Sex		5. Age		6. Date of Birth		7. Date of Death		8. Place of Birth		9. Usual Residence		10. Cause of Death		11. Manner of Death		12. Signature of Registrar		13. Signature of Medical Officer		14. Signature of Coroner	
Jane Smith		Female		32		1948-06-20		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
5. Name of Deceased		6. Sex		7. Age		8. Date of Birth		9. Date of Death		10. Place of Birth		11. Usual Residence		12. Cause of Death		13. Manner of Death		14. Signature of Registrar		15. Signature of Medical Officer		16. Signature of Coroner	
Robert Johnson		Male		58		1922-07-05		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
7. Name of Deceased		8. Sex		9. Age		10. Date of Birth		11. Date of Death		12. Place of Birth		13. Usual Residence		14. Cause of Death		15. Manner of Death		16. Signature of Registrar		17. Signature of Medical Officer		18. Signature of Coroner	
Mary White		Female		65		1915-08-10		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
9. Name of Deceased		10. Sex		11. Age		12. Date of Birth		13. Date of Death		14. Place of Birth		15. Usual Residence		16. Cause of Death		17. Manner of Death		18. Signature of Registrar		19. Signature of Medical Officer		20. Signature of Coroner	
David Brown		Male		40		1940-09-01		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
11. Name of Deceased		12. Sex		13. Age		14. Date of Birth		15. Date of Death		16. Place of Birth		17. Usual Residence		18. Cause of Death		19. Manner of Death		20. Signature of Registrar		21. Signature of Medical Officer		22. Signature of Coroner	
Elizabeth Green		Female		55		1925-04-12		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of Deceased		14. Sex		15. Age		16. Date of Birth		17. Date of Death		18. Place of Birth		19. Usual Residence		20. Cause of Death		21. Manner of Death		22. Signature of Registrar		23. Signature of Medical Officer		24. Signature of Coroner	
Thomas Black		Male		60		1920-03-08		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
15. Name of Deceased		16. Sex		17. Age		18. Date of Birth		19. Date of Death		20. Place of Birth		21. Usual Residence		22. Cause of Death		23. Manner of Death		24. Signature of Registrar		25. Signature of Medical Officer		26. Signature of Coroner	
Patricia Gray		Female		48		1932-05-18		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
17. Name of Deceased		18. Sex		19. Age		20. Date of Birth		21. Date of Death		22. Place of Birth		23. Usual Residence		24. Cause of Death		25. Manner of Death		26. Signature of Registrar		27. Signature of Medical Officer		28. Signature of Coroner	
William Hall		Male		52		1928-02-25		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
19. Name of Deceased		20. Sex		21. Age		22. Date of Birth		23. Date of Death		24. Place of Birth		25. Usual Residence		26. Cause of Death		27. Manner of Death		28. Signature of Registrar		29. Signature of Medical Officer		30. Signature of Coroner	
Margaret King		Female		62		1918-01-03		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
21. Name of Deceased		22. Sex		23. Age		24. Date of Birth		25. Date of Death		26. Place of Birth		27. Usual Residence		28. Cause of Death		29. Manner of Death		30. Signature of Registrar		31. Signature of Medical Officer		32. Signature of Coroner	
Charles Lee		Male		50		1930-07-14		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
23. Name of Deceased		24. Sex		25. Age		26. Date of Birth		27. Date of Death		28. Place of Birth		29. Usual Residence		30. Cause of Death		31. Manner of Death		32. Signature of Registrar		33. Signature of Medical Officer		34. Signature of Coroner	
Susan Clark		Female		42		1938-09-22		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
25. Name of Deceased		26. Sex		27. Age		28. Date of Birth		29. Date of Death		30. Place of Birth		31. Usual Residence		32. Cause of Death		33. Manner of Death		34. Signature of Registrar		35. Signature of Medical Officer		36. Signature of Coroner	
Daniel Evans		Male		55		1925-06-10		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
27. Name of Deceased		28. Sex		29. Age		30. Date of Birth		31. Date of Death		32. Place of Birth		33. Usual Residence		34. Cause of Death		35. Manner of Death		36. Signature of Registrar		37. Signature of Medical Officer		38. Signature of Coroner	
Jennifer Adams		Female		38		1942-03-05		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
29. Name of Deceased		30. Sex		31. Age		32. Date of Birth		33. Date of Death		34. Place of Birth		35. Usual Residence		36. Cause of Death		37. Manner of Death		38. Signature of Registrar		39. Signature of Medical Officer		40. Signature of Coroner	
Christopher Baker		Male		45		1935-04-18		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
31. Name of Deceased		32. Sex		33. Age		34. Date of Birth		35. Date of Death		36. Place of Birth		37. Usual Residence		38. Cause of Death		39. Manner of Death		40. Signature of Registrar		41. Signature of Medical Officer		42. Signature of Coroner	
Amanda Miller		Female		35		1945-01-20		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
33. Name of Deceased		34. Sex		35. Age		36. Date of Birth		37. Date of Death		38. Place of Birth		39. Usual Residence		40. Cause of Death		41. Manner of Death		42. Signature of Registrar		43. Signature of Medical Officer		44. Signature of Coroner	
Matthew Wilson		Male		40		1940-08-12		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
35. Name of Deceased		36. Sex		37. Age		38. Date of Birth		39. Date of Death		40. Place of Birth		41. Usual Residence		42. Cause of Death		43. Manner of Death		44. Signature of Registrar		45. Signature of Medical Officer		46. Signature of Coroner	
Nicole Taylor		Female		30		1950-02-28		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
37. Name of Deceased		38. Sex		39. Age		40. Date of Birth		41. Date of Death		42. Place of Birth		43. Usual Residence		44. Cause of Death		45. Manner of Death		46. Signature of Registrar		47. Signature of Medical Officer		48. Signature of Coroner	
Kevin Thomas		Male		48		1932-05-15		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
39. Name of Deceased		40. Sex		41. Age		42. Date of Birth		43. Date of Death		44. Place of Birth		45. Usual Residence		46. Cause of Death		47. Manner of Death		48. Signature of Registrar		49. Signature of Medical Officer		50. Signature of Coroner	
Stephanie Moore		Female		33		1947-03-08		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
41. Name of Deceased		42. Sex		43. Age		44. Date of Birth		45. Date of Death		46. Place of Birth		47. Usual Residence		48. Cause of Death		49. Manner of Death		50. Signature of Registrar		51. Signature of Medical Officer		52. Signature of Coroner	
Brandon White		Male		42		1938-06-25		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
43. Name of Deceased		44. Sex		45. Age		46. Date of Birth		47. Date of Death		48. Place of Birth		49. Usual Residence		50. Cause of Death		51. Manner of Death		52. Signature of Registrar		53. Signature of Medical Officer		54. Signature of Coroner	
Ashley Brown		Female		37		1943-04-10		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
45. Name of Deceased		46. Sex		47. Age		48. Date of Birth		49. Date of Death		50. Place of Birth		51. Usual Residence		52. Cause of Death		53. Manner of Death		54. Signature of Registrar		55. Signature of Medical Officer		56. Signature of Coroner	
Nathan Green		Male		44		1936-07-03		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
47. Name of Deceased		48. Sex		49. Age		50. Date of Birth		51. Date of Death		52. Place of Birth		53. Usual Residence		54. Cause of Death		55. Manner of Death		56. Signature of Registrar		57. Signature of Medical Officer		58. Signature of Coroner	
Hannah King		Female		36		1944-02-18		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
49. Name of Deceased		50. Sex		51. Age		52. Date of Birth		53. Date of Death		54. Place of Birth		55. Usual Residence		56. Cause of Death		57. Manner of Death		58. Signature of Registrar		59. Signature of Medical Officer		60. Signature of Coroner	
Isaac Lee		Male		41		1939-05-22		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
51. Name of Deceased		52. Sex		53. Age		54. Date of Birth		55. Date of Death		56. Place of Birth		57. Usual Residence		58. Cause of Death		59. Manner of Death		60. Signature of Registrar		61. Signature of Medical Officer		62. Signature of Coroner	
Grace Clark		Female		34		1946-01-05		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
53. Name of Deceased		54. Sex		55. Age		56. Date of Birth		57. Date of Death		58. Place of Birth		59. Usual Residence		60. Cause of Death		61. Manner of Death		62. Signature of Registrar		63. Signature of Medical Officer		64. Signature of Coroner	
Ethan Evans		Male		43		1937-03-12		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
55. Name of Deceased		56. Sex		57. Age		58. Date of Birth		59. Date of Death		60. Place of Birth		61. Usual Residence		62. Cause of Death		63. Manner of Death		64. Signature of Registrar		65. Signature of Medical Officer		66. Signature of Coroner	
Olivia Adams		Female		31		1949-04-20		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
57. Name of Deceased		58. Sex		59. Age		60. Date of Birth		61. Date of Death		62. Place of Birth		63. Usual Residence		64. Cause of Death		65. Manner of Death		66. Signature of Registrar		67. Signature of Medical Officer		68. Signature of Coroner	
Liam Baker		Male		46		1934-06-08		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
59. Name of Deceased		60. Sex		61. Age		62. Date of Birth		63. Date of Death		64. Place of Birth		65. Usual Residence		66. Cause of Death		67. Manner of Death		68. Signature of Registrar		69. Signature of Medical Officer		70. Signature of Coroner	
Sophia Miller		Female		39		1941-02-15		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
61. Name of Deceased		62. Sex		63. Age		64. Date of Birth		65. Date of Death		66. Place of Birth		67. Usual Residence		68. Cause of Death		69. Manner of Death		70. Signature of Registrar		71. Signature of Medical Officer		72. Signature of Coroner	
Noah Wilson		Male		47		1933-05-28		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
63. Name of Deceased		64. Sex		65. Age		66. Date of Birth		67. Date of Death		68. Place of Birth		69. Usual Residence		70. Cause of Death		71. Manner of Death		72. Signature of Registrar		73. Signature of Medical Officer		74. Signature of Coroner	
Ava Taylor		Female		32		1948-03-10		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
65. Name of Deceased		66. Sex		67. Age		68. Date of Birth		69. Date of Death		70. Place of Birth		71. Usual Residence		72. Cause of Death		73. Manner of Death		74. Signature of Registrar		75. Signature of Medical Officer		76. Signature of Coroner	
Caleb Thomas		Male		49		1931-07-01		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
67. Name of Deceased		68. Sex		69. Age		70. Date of Birth		71. Date of Death		72. Place of Birth		73. Usual Residence		74. Cause of Death		75. Manner of Death		76. Signature of Registrar		77. Signature of Medical Officer		78. Signature of Coroner	
Mia King		Female		30		1950-01-25		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
69. Name of Deceased		70. Sex		71. Age		72. Date of Birth		73. Date of Death		74. Place of Birth		75. Usual Residence		76. Cause of Death		77. Manner of Death		78. Signature of Registrar		79. Signature of Medical Officer		80. Signature of Coroner	
Elijah Lee		Male		44		1936-04-18		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
71. Name of Deceased		72. Sex		73. Age		74. Date of Birth		75. Date of Death		76. Place of Birth		77. Usual Residence		78. Cause of Death		79. Manner of Death		80. Signature of Registrar		81. Signature of Medical Officer		82. Signature of Coroner	
Charlotte Clark		Female		35		1945-02-12		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
73. Name of Deceased		74. Sex		75. Age		76. Date of Birth		77. Date of Death		78. Place of Birth		79. Usual Residence		80. Cause of Death		81. Manner of Death		82. Signature of Registrar		83. Signature of Medical Officer		84. Signature of Coroner	
Wyatt Evans		Male		43		1937-06-05		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
75. Name of Deceased		76. Sex		77. Age		78. Date of Birth		79. Date of Death		80. Place of Birth		81. Usual Residence		82. Cause of Death		83. Manner of Death		84. Signature of Registrar		85. Signature of Medical Officer		86. Signature of Coroner	
Zoe Adams		Female		31		1949-03-20		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
77. Name of Deceased		78. Sex		79. Age		80. Date of Birth		81. Date of Death		82. Place of Birth		83. Usual Residence		84. Cause of Death		85. Manner of Death		86. Signature of Registrar		87. Signature of Medical Officer		88. Signature of Coroner	
Carter Baker		Male		46		1934-05-10		1980-03-10		New York, NY		New York, NY		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
79. Name of Deceased		80. Sex		81. Age		82. Date of Birth		83. Date of Death															

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7514 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07493

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>				c. LENGTH OF STAY IN 1b <u>02 Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt # 220.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ronald</u> Middle <u>Lee</u> Last <u>Minnicks</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22, 1938</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Russell L. Minnicks</u>				14. MOTHER'S MAIDEN NAME <u>Goldie E. Smiley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-36-8643</u>		17. INFORMANT <u>Mr. Russell Minnicks,</u> Address <u>740 Greene St. Cumb.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO (b) <u>Aspiration of blood</u> DUE TO (c) <u>Basilar skull fracture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>upset automobile</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>upset automobile</u>					
20c. TIME OF INJURY Month, Day, Year <u>2:45 a.m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street Rt. 220 Near Cumberland, Alleg. Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July, 7, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Garden</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George,</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

TO DEPUTY MEDICAL EXAMINER: If certificate should be executed within 24 hours after death, If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7481 CERTIFICATE OF DEATH

Reg. Dist. No. 07494

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 251 Henderson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Paul Last Paul		4. DATE OF DEATH Month July Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1868 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired construction worker		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Paul		14. MOTHER'S MAIDEN NAME Margaret Kolb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-12-8692	
17. INFORMANT Arthur M. Paul		Address Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerotic heart disease DUE TO (b) Dissecting DUE TO (c) Dissecting Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3-4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 26, 1958 , to July 27, 1958 , that I last saw the deceased alive on July 26, 1958 , and that death occurred at 3:10 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE B. M. Schindler		ADDRESS (Street, city or town, state) 43 Everett, Cumberland, Md	
DATE SIGNED 7/27/58			
PHYSICIAN'S NAME (Type) Ruth E. Silcox			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/58	
22c. NAME OF CEMETERY OR CREMATORY St. Lukas Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland	
24a. REC'D BY REGISTRAR DATE JUL 30 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07495

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Barton		c. LENGTH OF STAY IN 1b 82 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Barton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Wesley Porter				4. DATE OF DEATH Month July Day 9 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1876	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Porter				14. MOTHER'S MAIDEN NAME Isabelle Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. John Porter-Barton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 Years 5 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1958 , to July 9, 1958 , that I last saw the deceased alive on July 9, 1958 , and that death occurred at 4:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1115 S. 4th St. Piedmont, W. Va. DATE SIGNED 7-10							
ACTUAL SIGNATURE Paul R. Wilson		M.D. 1115 S. 4th St. Piedmont, W. Va.					
PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/58		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Moscow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE JUL 14 '58	
				24b. REGISTRAR'S SIGNATURE Al. Leach			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7516 CERTIFICATE OF DEATH

07496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) TERESA First PURBAUGH Middle 1 Last				4. DATE OF DEATH Month July Day 31 Year 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-16-1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Patrick Collins				14. MOTHER'S MAIDEN NAME Elizabeth Lemmert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. 212-10-9137B			
17. INFORMANT Earl Purbaugh,, Mt. Savage, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Sided Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertensive Heart Disease DUE TO (c) Cerebral Hemorrhage - Rt. Hemisph. INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 15 yrs. 2- 10 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7/4/58 19 57 to 7/31 19 58 , that I last saw the deceased alive on 7/31/58 , 19 58 , and that death occurred at 3:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Broadway DATE SIGNED ACTUAL SIGNATURE Martin Rothstein, M.D. M.D. PHYSICIAN'S NAME (Type) Martin Rothstein, M. D. Frostburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-4-58		22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR AUG 5 '58	
24b. REGISTRAR'S SIGNATURE Alfred Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7482 CERTIFICATE OF DEATH

07497

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1137 Braddock Road</u>		d. STREET ADDRESS <u>1137 Braddock Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Van</u> Last <u>Rafter</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28 1902</u>
9. AGE (In years last birthday) yrs. <u>56</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads Comm</u>	
11. BIRTHPLACE (State or foreign country) <u>Kitzmilller Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roy O. Rafter</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Grimm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1919</u>		16. SOCIAL SECURITY NO. <u>217-10-5373</u>	
17. INFORMANT <u>Mrs. Doris Rafter, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 - 27</u> , 19 <u>55</u> , to <u>7 - 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 - 3</u> , 19 <u>58</u> , and that death occurred at <u>10:30 a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph W. Ballin</u>		ADDRESS (Street, city or town, state) <u>62 Greene St. Cumberland, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin</u>		DATE SIGNED <u>7-25-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rafter Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Kitzmilller Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Knight</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7483 CERTIFICATE OF DEATH

07498

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATTERSON CREEK 85 x 3			
c. LENGTH OF STAY IN 1b 2 DAYS				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL - MEMORIAL AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DENNIS		First Middle Last L. READD		4. DATE OF DEATH Month Day Year JULY 21 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 14, 1924	9. AGE (In years last birthday) yrs. 34	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B. AND O. R. R.		10b. KIND OF BUSINESS OR INDUSTRY TELEGRAPHER		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME DENNIS READD				14. MOTHER'S MAIDEN NAME LULUA COLLINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) none						INTERVAL BETWEEN ONSET AND DEATH 1 da. 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1958 to July 21, 1958 , that I last saw the deceased alive on July 21, 1958 and that death occurred at 8:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 140 Bedford S street DATE SIGNED 7/22/58 ACTUAL SIGNATURE James T. Hallinan M.D. PHYSICIAN'S NAME (Type) DR. JAMES HALLINAN Cumberland, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 24, 1958		22c. NAME OF CEMETERY OR CREMATORY FORT ASHBY CEMETERY		22d. LOCATION (City, town, or county) (State) FORT ASHBY, W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. HAFFER, CUMBERLAND, MARYLAND				24a. REC'D BY REGISTRAR JUL 25 58		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF BIRTH

SEX

RACE

OCCUPATION

EDUCATION

RELIGION

DATE OF DEATH

SEX

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

DATE OF BIRTH

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7484 CERTIFICATE OF DEATH

07499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 24 DAYS	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle MARY Last RICE		4. DATE OF DEATH Month JULY Day 30 Year 19 58.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26, 1923
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	11. IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Secretary		10b. KIND OF BUSINESS OR INDUSTRY Int. Revenue Service MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EDWARD HARTUNG		14. MOTHER'S MAIDEN NAME ANNA STOWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-14-1855	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma - Metastatic 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Seven to			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 58 , to July , 19 58 , that I last saw the deceased alive on July 30 , 19 58 , and that death occurred at 10:14 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Va Ave, Cumberland, Md DATE SIGNED 7/31/58 ACTUAL SIGNATURE Dr. O. G. Himmelwright PHYSICIAN'S NAME (Type) DR. O. G. HIMMELWRIGHT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE AUG 4 '58	
24b. REGISTRAR'S SIGNATURE W. E. Brown			

CERTIFICATE OF BIRTH

ALLEGED

ALLEGED

CONFIDENTIAL

DATE

DATE

NAME OF CHILD

NAME OF CHILD

SEX

SEX

DATE

DATE

NAME OF MOTHER

NAME OF MOTHER

DATE

DATE

NAME OF FATHER

NAME OF FATHER

NAME OF FATHER

NAME OF FATHER

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7485 CERTIFICATE OF DEATH

07500

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 HOURS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 CUMBERLAND d. STREET ADDRESS 214 COLE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BOBBY Middle BOY Last ROBERTSON		4. DATE OF DEATH Month JULY Day 22 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1958
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS. Days 2 Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CARL LEE ROBERTSON		14. MOTHER'S MAIDEN NAME JOAN ALISON LEWIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity of Vital Functions 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 July 1958 to 22 July 1958 , that I last saw the deceased alive on 22 July 1958 , and that death occurred at 6:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 630 Green St Cumberland, Md DATE SIGNED 23 July 58 ACTUAL SIGNATURE Leland Ransom M.D. PHYSICIAN'S NAME (Type) DR. LELAND RANSOM			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 23, 1958	
22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 24 '58	
24b. REGISTRAR'S SIGNATURE Arch Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2060254XVI

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JOHN ALFRED LEWIS		35		M		W		JULY 25, 1942		MEMORIAL HOSPITAL - GREENBELT, MD.	
MARRIAGE		SINGLE		COLORED		WHITE		JULY 25, 1942		JULY 25, 1942	
BIRTH		JULY 25, 1907		JULY 25, 1907		JULY 25, 1907		JULY 25, 1907		JULY 25, 1907	
FATHER		JAMES ALFRED LEWIS		JAMES ALFRED LEWIS		JAMES ALFRED LEWIS		JAMES ALFRED LEWIS		JAMES ALFRED LEWIS	
MOTHER		MARY ALICE LEWIS		MARY ALICE LEWIS		MARY ALICE LEWIS		MARY ALICE LEWIS		MARY ALICE LEWIS	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		DR. J. ALFRED LEWIS		DR. J. ALFRED LEWIS		DR. J. ALFRED LEWIS		DR. J. ALFRED LEWIS		DR. J. ALFRED LEWIS	
SIGNATURE OF REGISTRAR		J. ALFRED LEWIS		J. ALFRED LEWIS		J. ALFRED LEWIS		J. ALFRED LEWIS		J. ALFRED LEWIS	

Handwritten signature of J. Alfred Lewis

DR. J. ALFRED LEWIS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore avenue YMCA			d. STREET ADDRESS 1 Baltimore avenue YMCA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Whyllis Royce Robosson			4. DATE OF DEATH Month July Day 28 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1917		9. AGE (In years last birthday) 41 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman at sport shop.			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Thomas Robosson			14. MOTHER'S MAIDEN NAME Anna Robinette		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-16-4273		17. INFORMANT Mrs. Elder Moore Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status epilepticus --Asphyxiation 353.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
22d. LOCATION (City, town, or county) Cumberland		22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox			24a. REC'D BY REGISTRAR DATE AUG 4 '58		24b. REGISTRAR'S SIGNATURE Alberich

FOR STATE
HEALTH OFF.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
1935 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Thomas Robinson		35		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
1015 - 10th St., Baltimore, Maryland		Laborer		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
July 1, 1935		10:30 AM		Home		J. H. Smith, M.D.	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
J. H. Smith, M.D.		[Signature]		[Signature]		[Signature]	

7487 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAYSVILLE ✓	
		d. STREET ADDRESS 85 x 3	
3. NAME OF DECEASED (Type or print) ROBERT C		4. DATE OF DEATH July 29 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 12 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMPSON ROTRUCK		14. MOTHER'S MAIDEN NAME EVA HENLINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II		16. SOCIAL SECURITY NO. 236-50-0393	
17. INFORMANT Mildred Cutler Keyser, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute, postmortem 4 days 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 July, 1958 , to 30 July, 1958 , that I last saw the deceased alive on 30 July, 1958 , and that death occurred at 7:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer		DATE SIGNED 30 July 58	
PHYSICIAN'S NAME (Type) W. A. VAN ORMER		ADDRESS (Street, city or town, state) 1725 Centre St. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 Aug. 58	
22c. NAME OF CEMETERY OR CREMATORY Knobley Cemetery		22d. LOCATION (City, town, or county) (State) Martin, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Allen Rotruck		24a. REC'D BY REGISTRAR AUG 4 58	
ADDRESS Keyser, W. Va.		24b. REGISTRAR'S SIGNATURE Alfred	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2287 CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 10 1934		BALTIMORE		NATURAL	
AGE		SEX		RACE	
38		M		W	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JAN 10 1896		BALTIMORE		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		IMMEDIATE CAUSE	
LABORER		HEART DISEASE		CORONARY THROMBOSIS	
PREVIOUS ILLNESS		SIGNS AND SYMPTOMS		TREATMENT	
NONE		PAIN IN CHEST		NONE	
MEDICAL HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	
J. H. VAN COTT		J. H. VAN COTT		JAN 10 1934	

7488 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 02 years Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 231 Glenn Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE ADAM SIEBERT				4. DATE OF DEATH July 2 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 8, 1876	
9. AGE (In years last birthday) 82 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bank Employee		10b. KIND OF BUSINESS OR INDUSTRY Liberty Trust Co., Asst. Sec.		11. BIRTHPLACE (State or foreign country) North Branch, Maryland	
13. FATHER'S NAME Adam Siebert				14. MOTHER'S MAIDEN NAME Margaret Logsdon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-05-6087			
17. INFORMANT Mrs. Ida K. Siebert, Cumberland, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from March 7, 1957 to July 2, 1958 , that I last saw the deceased alive on June 27, 1958 , and that death occurred at 12:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. W. Trevaskis, Sr. M.D. Cumberland, Md				ADDRESS (Street, city or town, state) 220 Baltimore Ave. Cumberland, Md			
DATE SIGNED July 3, 1958				PHYSICIAN'S NAME (Type) Richard W. Trevaskis, Sr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR JUL 7 '58			
24b. REGISTRAR'S SIGNATURE Alfred							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Sex _____		Age _____	
Race _____		Birth Date _____	
Place of Birth _____		Date of Birth _____	
Usual Residence _____		Date of Death _____	
Cause of Death _____		Date of Death _____	
Manner of Death _____		Date of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7489 CERTIFICATE OF DEATH

Reg. Dist. No.

07504

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE M. SLIDER		4. DATE OF DEATH Month Day Year JULY 27 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND Twigg town		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MICHAEL TWIGG		14. MOTHER'S MAIDEN NAME NORA CRABTREE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Hypertensive cardiac vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis (c) Pneumonia			INTERVAL BETWEEN ONSET AND DEATH 5 years 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 27, 1958 to July 27, 1958 , that I last saw the deceased alive on July 27, 1958 , and that death occurred at 8:22 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED DR. G. SIMONS			
ACTUAL SIGNATURE DR. G. SIMONS		M.D. 1280000000	
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-30-58	22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUL 31 '58		24b. REGISTRAR'S SIGNATURE Alb. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7502 CERTIFICATE OF DEATH

Reg. Dist. No. **07505**

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 6 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Minera Hospital				d. STREET ADDRESS 48 Main			
3. NAME OF DECEASED (Type or print) Eva Mae Soult				4. DATE OF DEATH Month July Day 24 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 9, 1926	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.	
13. FATHER'S NAME Otto E. Cayton				14. MOTHER'S MAIDEN NAME Nerine Morrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Joseph Conroy-Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Atherosclerotic Cardiovascular Disease DUE TO (c) 1 day - 1 year						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 58				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6/20 , 19 58 , to 7/22 , 19 58 , that I last saw the deceased alive on 7/12 , 19 58 , and that death occurred at 11:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Davis, M.D.				ADDRESS (Street, city or town, state) 7 B ROADWAY			
DATE SIGNED 7/25/58							
PHYSICIAN'S NAME (Type) John B. Davis, M.D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/28, 58		22c. NAME OF CEMETERY OR CREMATORY Hamilton Cem.		22d. LOCATION (City, town, or county) (State) Hamilton W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ed Bral				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE JUL 29 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Edwards			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

Frostburg

6 No.

Frostburg

48 Main

Miners Hospital

Soult

Mae

Eva

June 2, 1926

x

Female White

35

W. Va.

U. S. a.

x

58

24

July

7490 CERTIFICATE OF DEATH

Reg. Dist. No. 07506

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7/1/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Stuby		4. DATE OF DEATH Month July Day 21 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/1866
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY	
10a. BIRTHPLACE (State or foreign country) Westernport, Maryland		10b. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. FATHER'S NAME John T. Zaes		12. MOTHER'S MAIDEN NAME Phoebe Wolford	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		14. SOCIAL SECURITY NO.	
15. INFORMANT P.O. Box 599 Address Cumberland, Md.		16. Allegany County Infirmary Records	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis		7 days
DUE TO (b) Chronic Inflammation		?
DUE TO (c) Cerebral arteriosclerosis		?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/1/58 , 19____, to 7/21/58 , 19____, that I last saw the deceased alive on 7/21/58 , 19____, and that death occurred at 7:55 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE James E. McLean M.D.	ADDRESS (Street, city or town, state) 49 Green St., Cumberland, Md.
PHYSICIAN'S NAME (Type) Dr. James E. McLean	DATE SIGNED 7/22/58

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/24/58	22c. NAME OF CEMETERY OR CREMATORY Philos	22d. LOCATION (City, town, or county) (State) Westernport, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Boal-Westernport, Md.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ADJUTANT GENERAL'S OFFICE
WASHINGTON, D. C.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		John T. Lane	
Sex		Male	
Age		8/29/1868	
Race		White	
Marital Status		Married	
Place of Birth		Kentwood, Maryland	
Residence at Time of Death		Kentwood, Maryland	
Cause of Death		Tuberculosis	
Date of Death		7/27/28	
Time of Death		11:00 AM	
Place of Death		Home	
Signature of Physician		Dr. James H. Nelson	
Signature of Registrar		J. H. Nelson	
Signature of Deceased		John T. Lane	
Signature of Family		Mrs. Lane	

7491 CERTIFICATE OF DEATH

Reg. Dist. No. 07507

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>512 Shriver Ave</u>				d. STREET ADDRESS <u>512 Shriver Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>S.</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert J. Schaevecker</u>				14. MOTHER'S MAIDEN NAME <u>Sophia M. Greisman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. James Beacham LeVak Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO <u>Coronary Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2nd day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>10-23-1949</u> to <u>7-19-1958</u> , that I last saw the deceased alive on <u>7-3-1958</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. J. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland Md</u>			
DATE SIGNED <u>7-21-58</u>							
PHYSICIAN'S NAME (Type) <u>Louis Stein Inc</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/22/58</u>		<u>Hillcrest Burial Park</u>		<u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>				ADDRESS <u>Cumb. Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 23 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7492 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 186 Thomas Street				f. STREET ADDRESS 186 Thomas Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida		First V. Tederick		Middle V. Tederick		Last V. Tederick	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1876	
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin T. Valentine				14. MOTHER'S MAIDEN NAME Mary Wolfe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. George Tederick, Cumberland, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-13-1958 to 6-14-1958 , that I last saw the deceased alive on 6-13-1958 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 126 Union Street DATE SIGNED July 14, 1958 ACTUAL SIGNATURE H. W. Eliason M.D. Dr. H. W. Eliason Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-16-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE JUL 17 '58		24b. REGISTRAR'S SIGNATURE W. H. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7503 CERTIFICATE OF DEATH

07509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Moscow			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ronnie Middle Wayne Last Timney				4. DATE OF DEATH Month July Day 26th Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25th. 1958	
9. AGE (In years last birthday) yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frostburg, MD.	
13. FATHER'S NAME John A. Timney				12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. John A. Timney, Moscow, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Cerebral aneurysm DUE TO (b) Prematurity DUE TO (c) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 25, 1958 to July 26, 1958 , that I last saw the deceased alive on July 26, 1958 , and that death occurred at 11 a. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.				ADDRESS (Street, city or town, state) Main St. DATE SIGNED July 26, 1958			
PHYSICIAN'S NAME (Type) LESLIE R. MILES, JR., M.D.				SIGNATURE Leslie R. Miles Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/26/1958		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONA CONING, MD.		24a. REC'D BY REGISTRAR DATE JUL 31 '58	
24b. REGISTRAR'S SIGNATURE W. H. Leach							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7493 CERTIFICATE OF DEATH

07510

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 226 N. MECHANIC STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last VOILS		4. DATE OF DEATH Month JULY Day 29 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 2
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GLEN VOILS		14. MOTHER'S MAIDEN NAME RITA A. WIGGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetus # I. Premature Separation Placenta DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fetus # II. Hypertension & manual DUE TO (c) removal of fetus & placenta following # (I)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:57 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Fuller 13/Whitworth M.D. Cumberland Md. 30 July 58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DR. FULLER WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 8-1-58	22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital	22d. LOCATION (City, town, or county) (State) Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE AUG 4 '58	24b. REGISTRAR'S SIGNATURE Albert Seuch

2060252xv0

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7494 CERTIFICATE OF DEATH

Reg. Dist. No. 47511

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 11 DAYS			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. #1 Cumberland, d. STREET ADDRESS Rt. 229 Cresaptown, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ROY LEE WARE			4. DATE OF DEATH Month Day Year JULY 24 19 58		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 14 1905		9. AGE (In years last birthday) yrs. 53
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY CELANESE Corp.		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
13. FATHER'S NAME FLOYD WARE			14. MOTHER'S MAIDEN NAME AMANDA Freil		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. 217-10-6044		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart Block DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myocardial infarction DUE TO (c) Coronary Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 6 da. 9 da. 14 da.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13, 19 58 , to July 24, 19 58 , that I last saw the deceased alive on July 24, 19 58 , and that death occurred at 7:50P M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 140 Bedford Street 7/25/58 ACTUAL SIGNATURE James P. Hallinan M.D. PHYSICIAN'S NAME (Type) DR. JAMES HALLINAN Cumberland, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
22d. LOCATION (City, town, or county) (State) Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUL 28 '58		24b. REGISTRAR'S SIGNATURE Alfred	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Wayne George. Cumberland, Maryland					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7517 CERTIFICATE OF DEATH

Reg. Dist. No. 07512

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Alleghany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Oldtown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Oldtown	
c. LENGTH OF STAY IN 1b 2 YEARS		d. STREET ADDRESS Route 1, Oldtown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 1, Oldtown, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTIE Middle AGNES Last WIGFIELD		4. DATE OF DEATH Month July Day 29 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) OLDTOWN, MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME RILEY HARTLEY	
14. MOTHER'S MAIDEN NAME MELINDA RECKLEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT REV. HARTLEY WIGFIELD, LA VALE, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Dischilus melleus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1958 to July 17, 1958 that I last saw the deceased alive on July 15, 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David T. Rees		ADDRESS (Street, city or town, state) Montgomery Avenue DATE SIGNED 31 July 1958	
PHYSICIAN'S NAME (Type) DAVID T. REES		Montgomery Ave. Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/1/58	22c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK	22d. LOCATION (City, town, or county) (State) CUMBERLAND, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. HAFFER, CUMBERLAND, MARYLAND		24a. REC'D BY REGISTRAR AUG 5 '58 24b. REGISTRAR'S SIGNATURE Arthur	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7518 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) BERTHA First CLARE Middle WINNER Last		4. DATE OF DEATH July Month 24 Day 19 Year 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-1901
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Martin		14. MOTHER'S MAIDEN NAME Mary O'Connor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Aloysius Winner, Mt. Savage, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-58	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE JUL 28 '58	
24b. REGISTRAR'S SIGNATURE Ar. Smith		DATE SIGNED July 24, 1958	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07513

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1219 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17658
1802
856

3006
856

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Maryland
1902